February 13, 2002

Replacement Pages for

Massachusetts Cancer Registry Abstracting and Coding Manual For Hospitals, Fourth Edition

Replace these pages in your copy (or copies) of the Manual. These pages were distributed Feb. 13, 2002 at the Massachusetts Cancer Registry Quality Assurance Workshop in Framingham (and mailed to facilities not attending that Workshop the following week).

The replacement pages for the MCR Manual are --
in the Tumor Data section: pages 100, 101, 103-105;
in the Treatment Data section: pages 161-162, 170, 173, 176, 178
in Appendix D: pages D-42, D-43, D-68, D-72
in Appendix E: pages E-10, E-11, E-20, E-21, E-23, E-24, E-26, E-27, E-31, E-65, E-89, E-101, E-102

The entire Manual posted on this website (all sections) is as originally posted in December 2001; the February 2002 Replacement Pages are not included. If you download the changed sections (Tumor Data, Treatment Data, Appendix D or Appendix E) from the original posting, be sure to also download and use the appropriate Replacement Pages listed above.

Questions? Contact mary.mroszczyk@state.ma.us by e-mail or telephone 617-624-5659.

EOD -- Tumor Size

NAACCR Version 9.1 Item 780, columns 390-392

The MCR has adopted the SEER Extent of Disease rules for coding Tumor Size, with the following exceptions:

- For Hodgkin and non-Hodgkin lymphomas (9590-9699, 9702-9719) and Kaposi sarcoma (9140), SEER uses this field to record a patient's HIV or AIDS status; do NOT record this for the MCR. Record **999** for lymphomas and Kaposi sarcoma.
- For mycosis fungoides (9700) and Sezary syndrome (9701) of the penis (except body of penis, C60.2), scrotum, skin and vulva (C60.0, C60.1, C60.8, C60.9, C63.2, C44._, C51._), SEER uses this field to record peripheral blood involvement; do NOT record this for the MCR. Code **999** for these diseases.
- For any Tumor Size < 2 millimeters, SEER uses code **002** because code **001** is reserved by SEER to indicate only a microscopic focus of invasion. The COC uses **990** for microscopic foci for diagnoses as of January 1, 2002, and uses **001** for an actual Tumor Size of (or rounded to) 1 mm. The MCR will adopt the COC rule.
- SEER uses code **990** for a Tumor Size rounding to or greater than 990 mm; COC reserves this code for microscopic foci of invasion for diagnoses as of January 1, 2002, and uses **989** for sizes rounding to 989 mm or larger. The MCR will adopt these COC rules.
- For breast cancers, SEER uses code **002** for non-palpable tumors discovered by mammography/ xerography only without a recorded Tumor Size; a breast tumor <u><=</u>3mm in size is coded **003**. For the COC and MCR, use **002** and **003** for breast tumors rounding to 2 and 3 mm, respectively.
- For Paget disease of the nipple with no demonstrable tumor, SEER uses code **997**. The COC has not adopted this coding convention and would presumably want such cases coded **000**. The MCR will accept either coding convention for these cases.
- SEER uses code **998** for certain diagnoses, and when certain terms are used at certain sites:

  "entire circumference" for esophageal cancers;

  linitis plastica (8142/3), "diffuse", or "widespread--3/4 or more" for stomach cancers;

  familial/multiple polyposis (8220-8221) for colorectal cancers;

  "diffuse", "entire lobe" or "entire lung" for lung and bronchus cancers;

  inflammatory carcinoma (8530/3), "diffuse" or "widespread--3/4 or more" for breast cancers.

  The COC dropped this rule for diagnoses as of January 1, 2002. The MCR will accept either coding convention; please use a narrative field to clarify this situation for us.

For All Cases <u>Except</u> Malignant Melanoma of the Skin, Conjunctiva, Penis, Scrotum, or Vulva
(C44._, C69.0, C60.0, C60.1, C60.8, C60.9, C63.2, C51._, 8720-8790)

Use three digits to record the size of the primary tumor *in millimeters*. This is the <u>largest dimension</u> or the diameter of the primary tumor <u>before treatment</u> with radiation, chemotherapy, hormone therapy or immunotherapy.

Enter the size given in the pathology report for surgically excised tumors, unless the patient received treatment (radiation, chemotherapy, hormone therapy, immunotherapy) before the surgery. If neoadjuvant therapy occurred, use pre-treatment clinical Tumor Size information rather than the surgical results. Do not calculate a tumor size by adding the sizes of pieces or chips of tissue as they might not be from the same location or might represent only a small portion of a large tumor. Do not add measurements recorded in biopsy and resection reports. Use the report that documents the largest size. If an excisional biopsy is performed and residual tumor is found during a wider resection, base Tumor Size on the excisional biopsy report alone *unless* the residual tumor is found to be larger than the portion that was excised.

There are times when a pathologic Tumor Size is not available and clinical information must be used. The pathology report may not identify Tumor Size, or the tumor may not have been surgically excised. In these cases, use the Tumor Size documented in the following reports (listed in order of preference): 1. Operative reports; 2. Scans; 3. X-rays; 4. Physical exams.

To convert centimeters to millimeters, move the decimal point one digit to the right (i.e., multiply the number of centimeters by 10).

Example: 2.1 centimeters is equivalent to 21 millimeters, so **021** would be entered for Tumor Size.

The following are millimeter equivalents of centimeters and inches:

1.0 mm	=	0.1 cm
10.0 mm	=	1.0 cm
1.0 cm	≈	0.394 inch
1.0 inch	≈	2.5 cm
1.0 inch	≈	25.0 mm

Round off to the nearest millimeter.

Example: Tumor size 2.19 cm. This is 21.9 mm, so round to the nearest millimeter and enter **022**.

Code the largest size when a tumor has multiple measurements.

Examples:

- Record size as **033** mm for a 2 x 3.3 x 2.5 cm tumor.
- Record size as **045** mm for a 4.5 x 2.0 cm tumor.

Do not use the size of the entire *specimen* for Tumor Size.

Examples:

- A patient has an excisional breast biopsy. The pathology report states that the specimen measures 1 cm x 2 cm, but does not state the actual size of the tumor. Do not use the specimen size of 1 cm x 2 cm; rather, code the size based on information from the operative report, mammography, or physical exam.
- A patient has a colonoscopy with polypectomy. The pathology report reads "a 1.5 x .6 cm polyp with a microscopic focus of adenocarcinoma *in situ*." Enter **990** for Tumor Size because of the term “microscopic” (see **Table IV.2**, pages 102-103).

Table IV.2 continued

Eggs and Miscellaneous Foods:

Object	mm	Object	mm
Doughnut	**090**	Egg, Pigeon	**030**
Egg	**050**	Egg, Robin	**020**
Egg, bantam	**040**	Lentil	**009**
Egg, goose	**070**	Millet	**009**
Egg, hen	**030**		

Money:

Object	mm
Dime	**010**
Dollar, silver	**040**
Half dollar	**030**
Nickel	**020**
Penny	**010**
Quarter	**020**
Silver Dollar	**040**

Other:

Object	mm
Ball, golf	**040**
Ball, ping-pong	**030**
Ball, tennis	**060**
Baseball	**070**
Eraser, pencil	**009**
Fist	**090**
Marble	**010**
Match head	**009**
Microscopic	**990**
Pencil eraser	**009**

Enter code **000** when the primary location of a solid tumor is not found (AJCC T0). Use this code only for solid tumors.

Example: A patient has a biopsy of an axillary mass. The pathology report identifies infiltrating duct carcinoma in an axillary node. Workup reveals no breast lesion. Enter Tumor Size **000**.

Exception: For the MCR, if your data system permits, you may enter code **997** for cases of Paget disease of the nipple when no underlying breast tumor can be found. Enter **000** if you want to comply with COC data standards.

Use code **009** if an inexact measurement of "less than 1 cm" is given.

Use code **019** if an inexact measurement of "less than 2 cm" is given.

If only an inexact estimate involving a size range is available, code the larger size mentioned. For example, if "3 to 4 cm" is the best information you have, code **040**.

For the MCR, if your data system permits, you may enter code **998** for Tumor Size when the following terms describe the tumor involvement at these sites:

- Esophagus (C15._): "entire circumference"
- Stomach (C16._): "diffuse"; "widespread"; "3/4 or more"; "linitis plastica"
- Colon/rectosigmoid junction/rectum (C18.0-C20.9): familial/multiple polyposis (Histologic Type Code 8220 or 8221 with a Behavior Code of 2 or 3)
- Lung (C34._): "diffuse"; "entire lobe of lung"
- Breast (C50._): "diffuse"; 'widespread"; "3/4 or more"; "inflammatory carcinoma"

Code **998** is no longer considered valid for the COC for diagnoses as of January 1, 2002. Ignore the terms listed above when coding Tumor Size for the COC, but please record the use of these terms in a narrative field for the MCR.

Enter code **999** in the following circumstances:

- when Tumor Size is not recorded or not available
- when the pathologic report gives no Tumor Size and there is no clinical Tumor Size information (for example, the primary tumor was not palpable on physical examination and could be not seen by imaging techniques)
- when transurethral resections of the prostate or bladder have produced chips and fragments of tissue (Do not estimate Tumor Size by adding the sizes of these chips or fragments together.) If a clinical Tumor Size can be found (perhaps from physical exam, ultrasound or cystoscopy), then record that Size.
- for the following sites/diseases in which a "tumor size" is not applicable --
    - hematopoietic and reticuloendothelial systems (C42.-)
    - ill-defined primary site (C76.-)
    - lymph nodes (C77.-)
    - unknown primary site (C80.9)
    - Kaposi sarcoma (9140)
    - lymphoma (all sites) (9590-9699, 9702-9729)
    - mycosis fungoides and Sezary syndrome of skin, penis, scrotum, vulva (9700, 9701, C44.-, C60.0, C60.1, C60.8, C60.9, C63.2, C51.-)
    - plasma cell tumors (9731-9734)
    - immunoproliferative diseases (9760-9769)
    - chronic myeloproliferative disorders, other hematologic disorders, and myelodysplastic syndromes (9950-9989)
    - Letterer-Siwe disease (9754)
    - leukemia (9800-9948)

Codes follow (for non-melanomas):

Tumor Size	**Code**
no primary tumor found	**000**
rounds to 1 mm (0.1 cm) or less	**001**
rounds to 2 mm (0.2 cm)	**002**
. . .	. . .
rounds to 988 mm (98.8 cm)	**988**
rounds to 989 mm (98.9 cm) or more	**989**
microscopic focus or foci only	**990**
Paget disease of nipple with no underlying tumor	**997***
diagnoses/terms on bottom of page 103	**998***
unknown; not stated; sites/diseases shown above	**999**

* code not valid for the COC for diagnoses as of January 1, 2002, but acceptable to the MCR; you may use **000** as an alternative to **997**, and you may use an actual (or unknown) Tumor Size in place of **998** for the MCR

For Malignant Melanoma of the Skin, Conjunctiva, Penis (except C60.2 Body of penis), Scrotum, or Vulva ONLY

(Primary Sites C44._, C51._, C60.0, C60.1, C60.8, C60.9, C63.2, C69.0 with Histologic Type Codes 8720-8790)

For cases diagnosed in 2002 and thereafter, the COC will adopt the SEER Extent of Disease coding rules for these cases. The MCR is adopting them effective immediately; for pre-2002 diagnoses, you may code Tumor Size using *either* the COC or SEER rules when reporting these cases to the MCR, although we would prefer the SEER rules if possible.

For malignant melanoma of the primary sites listed above, do not record the size of the primary tumor in this field. Record the thickness of the primary tumor or its depth of invasion (Breslow measurement) before tumor-reducing treatment. Do not record this in millimeters -- use hundredths of millimeters instead (round to the nearest hundredth of a mm).

For completely *in situ* (noninvasive) melanomas of the sites above (including lentigo maligna 8742/2 and precancerous melanosis 8741/2), there is no "depth of invasion" to record in this field (not applicable), so use code **999**.

Tumor Thickness / Depth of Invasion	Code
no primary tumor found	**000**
up to 0.01 mm; 0.01 mm	**001**
. . .	. . .
0.10 mm (0.01 cm)	**010**
. . .	. . .
1.00 mm (0.1 cm)	**100**
. . .	. . .
2.00 mm (0.2 cm)	**200**
. . .	. . .
9.90 mm (0.99 cm) or more	**990**
unknown; not stated; completely *in situ* / noninvasive melanoma	**999**

Scope of Regional Lymph Node Surgery -- Summary

NAACCR Version 9.1 field "Rx Summ--Scope Reg LN Sur", Item 1292, column 611

Using the codes for the appropriate primary site in Appendix D, report the Scope of Regional Lymph Node Surgery done at your facility and elsewhere if known to you.

Scope of Regional Lymph Node Surgery -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Scope Reg LN Sur", Item 672, column 343

Using the codes in Appendix D, code just the Scope of Regional Lymph Node Surgery done at your facility. Include procedures done in a staff physician's office (if available).

Number of Regional Lymph Nodes Removed

Record the number of regional nodes microscopically examined and documented in the pathology report from only the surgical procedure(s) coded in the "Surgery of Primary Site" fields. Do not add numbers of nodes removed at different surgical events.

If *no* regional lymph nodes are identified in the pathology report, code **00** here, even if the surgical procedure usually includes a lymph node dissection (e.g., modified radical mastectomy), or if the operative report documents the removal of nodes.

Note: Because these fields are *not* cumulative and not affected by timing, they do not duplicate the field "Regional Nodes Examined" (which describes *all* regional nodes removed during the entire first course of treatment). Do not automatically copy one field to another. (See pages 142-143 for the field "Regional Nodes Examined".)

For all cases with a *primary site* of lymph nodes (C77._), fill the Number of Regional Lymph Nodes Removed fields with code **99***. Do *not* code *all* lymphomas this way -- just those with lymph node primary sites. Also use code **99*** for leukemias.

* If your data system will not allow Scope of Regional Lymph Node Surgery to be coded **9** and Number of Regional Lymph Nodes Removed to be coded **99** for nodal lymphomas and leukemias, then coding **0** and **00** in these fields will not be called an error.

For all cases with an unknown primary site (C80.9), fill the Number of Regional Lymph Nodes Removed fields with code **99***.

There are **NO** regional lymph nodes for the brain (C71._, C70.0). Enter code **99*** for all cases with a brain/cerebral meninges primary site code.

Codes for all cases *except* leukemias and those with primary sites Brain, Cerebral Meninges, Lymph Nodes, and Unknown Primary Site follow:

Number of Regional Lymph Nodes Removed	**Code**
None removed	**00**
One removed	**01**
Two removed	**02**
.....	.....
Ninety or more removed	**90**
No regional lymph node(s) were actually surgically removed, but a regional lymph node aspiration was performed.	**95**
Regional lymph node removal was documented as a sampling and the exact number of lymph nodes was unknown/not stated.	**96**
Regional lymph node removal was documented as a dissection and the exact number of lymph nodes was unknown/not stated.	**97**
Regional lymph nodes were surgically removed, but the number was unknown/not stated and the removal was not documented as a "sampling" or "dissection".	**98**
Unknown number removed; number removed not stated; death certificate only	**99**

Number of Regional Lymph Nodes Removed -- Summary

NAACCR Version 9.1 field "Rx Summ--Reg LN Examined", Item 1296, columns 613-614

Using the codes above, record the Number of Regional Lymph Nodes Removed at your facility and elsewhere for the surgical procedure coded in "Surgery of Primary Site -- Summary".

Number of Regional Lymph Nodes Removed -- At This Facility

NAACCR Version 9.1 field "Rx Hosp--Reg LN Removed", Item 676, columns 345-346

Using the codes above, record just the Number of Regional Lymph Nodes Removed at your facility for the procedure coded in "Surgery of Primary Site -- At This Facility".

* If your data system will not allow Scope of Regional Lymph Node Surgery to be coded **9** and Number of Regional Lymph Nodes Removed to be coded **99** for these primary sites, then coding **0** and **00** in these fields will not be called an error.

Chemotherapy may be divided into the following four groups:

Group I: Alkylating Agents

Busulfan (Myleran)	DTIC (Dacarbazine)
Carmustine (Lomustine)	Mechlorethamine (Mustargen)
Chlorambucil (Leukeran)	Phenylalanine mustard (Melphalan)
Cyclophosphamide (Cytoxan)	Temodol (Temozolomide)*
	Triethylene-thiophosphoramide (Thio-TEPA)

Group II: Antimetabolites

Folic acid analogs:	Methotrexate (Amethopterin, MTX)
Pyrimidine analogs:	5-Fluorouracil (5-FU), Xeloda (Capecitabine)*
Purine analogs:	6-Mercaptopurine (6-MP)

Group III: Natural Products

Antitumor antibiotics:	Bleomycin (Blenoxane)
	Dactinomycin (Actinomycin D)
	Daunorubicin (Daunomycin)
	Doxorubicin (Adriamycin)
	Mitomycin C (Mutamycin)
	Pentostatin (Nipent)*
Vinca (plant) alkaloids:	Vinblastine (VBL, Velban)
	Vincristine (VCR, Oncovin)
Enzymes:	L-Asparaginase (Elspar)*

Group IV: Miscellaneous Agents

Cis-diammine dichloroplatinum II (Cisplatin)
Hydroxyurea (Hydrea)
Procarbazine (Matulane)

See the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed.* (1993) for a comprehensive list of chemotherapy agents in use at the time of its publication (pages 5-28).

When a patient has an adverse reaction to initial chemotherapy, a physician may change one of the agents being administered. If the replacement drug belongs to the same group (Groups I-IV shown above) as the original drug, there is considered to have been *no change in the regimen* and this is just a continuation of the planned first course of therapy; but if the replacement agent falls into a different group than the original drug, then this is considered a *new regimen* and *subsequent therapy* (i.e., not first-course and not collected by the MCR).

* Pentostatin and L-Asparaginase are listed in *Book 8* as Biological Response Modifiers, but errata issued by SEER changed their category to Chemotherapy. Xeloda and Temodol are not listed in *Book 8*, but SEER issued a bulletin on new anti-cancer drugs in May 2000 which stated that these should be coded as Chemotherapy.

HORMONE / STEROID / ENDOCRINE THERAPY

Hormones promote hormonal withdrawal or hormonal interface to alter cancer growth. Hormonal therapy may effect a long-term control of the cancer, but it is not usually used to "cure" the cancer.

Code the type of Hormone Therapy the patient received as part of first course of therapy. Record surgery performed for hormonal effect (such as orchiectomy) and radiation given for hormonal effect.

Hormones and Antihormones

Report cancer-directed treatment with hormones and antihormones for all sites and types of cancer. Report cancer-directed use of adrenocorticotrophic hormones for the treatment of leukemias, lymphomas, multiple myeloma, and breast and prostate cancers.

Code Prednisone as Hormonal Therapy when it is given in combination with Chemotherapy (e.g., MOPP or COPP) for cancer of *any* site. If administered for other reasons, do *not* code such agents as Hormone Therapy.

Examples:

- A patient with advanced cancer is given Prednisone to stimulate appetite. Do not code this.
- A patient with advanced lung cancer has multiple brain metastases. The physician orders Decadron to reduce edema in the brain and relieve neurological symptoms. This use of Decadron is not coded as Hormone Therapy.

Hormone classifications include the following:

adrenocorticosteroids (Prednisone, Decadron)

androgens (Halotestin)

antiestrogens (Tamoxifen, Nolvadex, Arimidex, Faslodex*)

estrogens (DES, diethylstilbestrol)

hormone synthesis inhibitors (Elipten, Cytadren)

progestins (Provera, Megace)

For a more complete list of hormonal agents, see the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (1993).

* Arimidex (Anastrozole) and Faslodex are not listed in *Book 8*, but SEER issued a bulletin on new anti-cancer drugs in May 2000 noting that these should be coded as Hormone Therapy.

IMMUNOTHERAPY

Immunotherapy (biological response modifier therapy, BRM) consists of biological or chemical agents that alter the immune system or change a patient's response to tumor cells. Code only Immunotherapy that the patient received as part of first course of therapy. Immunotherapy agents include:

allogeneic cells
BCG vaccine
bone marrow transplant
C-Parvum
Herceptin (Trastuzumab)**
Interferon
Interleukin
LAK (lymphokine activated killer) cells
Levamisole
MVE-2
Pyran copolymer
Rituxan (Rituximab)**
Thymosin
vaccine therapy
virus therapy

Refer to the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*. (1993), pages 55-67, for a complete list of Immunotherapy agents.

Note: *Book 8* lists Epogen (Procrit), Sandostatin and Neupogen as BRM agents, but errata issued by SEER corrected these listings to the "ancillary" drug category. Epogen, Sandostatin and Neupogen should not be coded in any First Course of Treatment modality. *Book 8* also lists Pentostatin and L-Asparaginase as BRM agents, but SEER errata corrected these to be Chemotherapy agents.

Use the following codes for Immunotherapy:

no Immunotherapy given	**0**
biological response modifier (BRM)	**1**
bone marrow transplant - autologous	**2**
bone marrow transplant - allogeneic	**3**
bone marrow transplant, NOS	**4**
stem cell transplant	**5**
combination of **1** and any of **2-5**	**6**
patient/guardian refused Immunotherapy	**7**
Immunotherapy recommended, but unknown if administered	**8**
unknown* if Immunotherapy recommended or administered	**9**

* There is reason to believe that Immunotherapy was recommended or given, but there is no information to confirm this.

** Herceptin and Rituxan are not listed in *Book 8*, but SEER issued a bulletin on new anti-cancer drugs in May 2000 which stated that they should be coded as Hormone Therapy.

OTHER CANCER-DIRECTED THERAPY

Other Cancer-Directed Therapy includes treatments given as part of first course of therapy designed to modify or control cancer cells that are not defined in the Surgery, Radiation, Chemotherapy, Hormone Therapy or Immunotherapy fields.

Examples:

- tumor embolization (arterial block) if the surgeon's intent is to kill tumor cells
- any cancer-directed experimental drug that cannot be classified as Chemotherapy, Hormone Therapy or Immunotherapy (code **2**); this includes Thalidomide, Angiostatin, Endostatin and Marmistat when used as anti-angiogenesis agents. In a bulletin on new new drugs issued by SEER in May 2000, it was stated that these four agents should be coded as Other Cancer-Directed Therapy until further notice.
- hyperbaric oxygen (as an adjunct to definitive treatment)
- hyperthermia (given alone or in combination with Chemotherapy, as in isolated heated limb perfusion for melanoma)
- double-blind clinical trial information where the type of agent administered is unknown and/or there is use of a placebo (code **3**). After the code is broken, report the treatment under the appropriate modality (e.g., if the agent is revealed to be a Chemotherapy agent, code it as Chemotherapy and delete the Other Therapy code that had been applied temporarily). (To report changes to data already submitted to the MCR, call a cancer registrar at 617-624-5645).
- unorthodox and unproven treatments if these are the *only* treatment received by the patient (code **6**). These include but are not limited to: Laetrile, Krebiozen, Iscador; acupuncture/pressure; homeopathic or herbal medicine, nutritional supplements; bioelectromagnetic applications; relaxation techniques, humor therapy. If the patient receives a combination of such unorthodox treatments in addition to cancer-directed Surgery, Radiation, Chemotherapy, Hormone Therapy or Immunotherapy, then do *not* code the unorthodox treatment. See *SEER Program Code Manual, 3rd Ed*. (1998) pp. 140-141 for a full discussion.

{Do *not* code ancillary (non cancer-directed) drugs. These have *no coding scheme.*) You may record their use in a treatment Narrative field, but since their effects are not cancer-directed, it is not necessary to report them to the MCR.

Examples: Allopurinol, Epogen*, G-CSF (granulocyte colony stimulating factor), Leucovorin, Neupogen*, Sandostatin*, Aredia (Pamidronate)**

Note: This is only a partial list. Refer to the *SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd Ed*., pages 35-46, for a more complete listing.

* Epogen, Sandostatin and Neupogen were incorrectly listed in *Book 8* as BRM agents. SEER errata corrected these listings to the "ancillary" drug category.

** Aredia is not listed in *Book 8*, but SEER issued a bulletin on new drugs in May 2000 which stated that this should be classified as an ancillary drug.}

SPLEEN and LYMPH NODES

SCOPE OF REGIONAL LYMPH NODE SURGERY

For lymph node primary sites, use code **9** only.*

For spleen primaries, use codes **0**, **1** or **9**:

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate only

* If your data system will not allow you to enter **9** for nodal lymphomas, a code **0** will not be called an error.

SURGERY OF OTHER REGIONAL SITES, DISTANT SITES OR DISTANT LYMPH NODES

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

2 Other regional site(s)

5 Distant lymph node(s)

6 Distant site(s)

7 Combination of **6** WITH **2** or **5**

9 Unknown; not stated; death certificate only

RECONSTRUCTION - FIRST COURSE

Use the following code only:

9 Not applicable (At this time, reconstructive procedures are not being collected for these sites.)

SKIN

C44.0 - C44.9

SURGERY OF PRIMARY SITE

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- **11** Photodynamic therapy (PDT)
- **12** Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- **13** Cryosurgery
- **14** Laser ablation

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- **21** Photodynamic therapy (PDT)
- **22** Electrocautery
- **23** Cryosurgery
- **24** Laser ablation
- **25** Laser excision
- **26** Polypectomy
- **27** Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Biopsy of primary tumor followed by a gross excision of the lesion
- **31** Shave biopsy followed by a gross excision of the lesion; Mohs' surgery
- **32** Punch biopsy followed by a gross excision of the lesion
- **33** Incisional biopsy followed by a gross excision of the lesion

Less than a wide excision, less than 1 cm margin.

40 Wide excision or re-excision of lesion or minor (local) amputation, NOS

Margins of excision are 1 cm or less. Margins may be microscopically involved.
Local amputation is the surgical resection of digits, ear, eyelid, lip, or nose.

50 Radical excision of a lesion, more than 1 cm, NOS

Margins of excision are greater than 1 cm and grossly tumor-free. The margins may be microscopically involved.

60 Major amputation, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate only

BRAIN and OTHER PARTS OF CENTRAL NERVOUS SYSTEM

SCOPE OF REGIONAL LYMPH NODE SURGERY

There are **NO regional lymph nodes** for the **brain**. Code "unknown" (**9**) for all brain primaries (C70.0, C71._).* **Central nervous system** sites, however, **do** have regional lymph nodes.

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate only

* If your data system will not allow **9** to be entered for these cases, then code **0** will not be considered an error.

SURGERY OF OTHER REGIONAL SITES, DISTANT SITES OR DISTANT LYMPH NODES

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- **2** Other regional site(s)
- **5** Distant lymph node(s)
- **6** Distant site(s)
- **7** Combination of **6** WITH **2** or **5**

9 Unknown; not stated; death certificate only

RECONSTRUCTION - FIRST COURSE

Use the following code only:

9 Not applicable (There are no known reconstructive procedures for this site.)

ALL OTHER SITES

SURGERY OF PRIMARY SITE (cont.)

30 Simple / partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation

50 Surgery stated to be "debulking"

60 Radical surgery (partial or total removal of the primary site WITH an en bloc resection (partial or total removal) of other organs)

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate only

SCOPE OF REGIONAL LYMPH NODE SURGERY

For an unknown primary site (C80.9) and leukemias, enter code **9** only.*

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate only

* If your data system will not allow **9** to be coded for these cases, a code **0** will not be called an error.

SURGERY OF OTHER REGIONAL SITES, DISTANT SITES OR DISTANT LYMPH NODES

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph node(s)

4 Distant site(s)

5 Combination of **4** WITH **2** or **3**

9 Unknown; not stated; death certificate only

RECONSTRUCTION - FIRST COURSE

Use the following code only:

9 Not applicable (At this time, reconstructive procedures are not being collected for these sites.)

field: **Diagnostic Confirmation**
edits: 31. Diagnostic Confirmation (SEER DXCONF) p. E-47
32A. Diagnostic Confirmation, Behavior Code (SEER IF31) p. E-47
32B. Diagnostic Confirmation, Behavior ICD03 (SEER IF31) p. E-48
33A. Diagnostic Confirmation, Histologic Typ(SEER IF48) p. E-48
33B. Diagnostic Confirmation, Histology ICD03(SEER IF48 p. E-48
146. RX Summ--Surg Prim Site, Diag Conf (SEER IF76) p. E-90
178. Type of Report Srce(DC/AO), Diag Conf (SEER IF05) p. E-108

field: **EOD--Extension**
edits: none

field: **EOD--Extension Prost Path** (called EOD -- Extension Prostate Pathology in MCR Manual)
edits: none

field: **EOD--Lymph Node Involv** (called EOD -- Lymph Node Involvement in MCR Manual)
edits: none

field: **EOD--Tumor Size**
edit: 35. EOD--Tumor Size (NAACCR) p. E-50
36A. EOD–Tumor Size, Primary Site (NAACCR) p. E-50
36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR) p. E-51

field: **Grade** (called Grade / Differentiation / Immunophenotype in MCR Manual)
edits: 37. Grade (COC) p. E-51
56A. Morphology--Type&Behavior (SEER MORPH) p. E-59
56B. Morphology--Type&Behavior ICDO3 (SEER MORPH) p. E-61

field: **Histologic Type ICD-O-3** (called ICD-O-3 Histologic Type Code in MCR Manual)
edits: 41B. Histologic Type ICDO3 (COC) p. E-53
56B. Morphology--Type&Behavior ICDO3 (SEER MORPH) p. E-61
10B. Age, Primary Site, Morphology ICDO3 (NAACCR IF15) p. E-38
12B. Behavior ICDO3, Histologic Type ICDO3 (NAACCR/MCR) p. E-41
33B. Diagnostic Confirmation, Histology ICD03(SEER IF48 p. E-48
34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR p. E-49
36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR) p. E-51
40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
43. Histology ICDO2, Histology ICDO3 (NAACCR) p. E-53
42B. Histology ICDO3, Date of Diagnosis (NAACCR) p. E-53
49A. Laterality, Primary Site, Morph ICDO3 (NAACCR IF42) p. E-56
50. Lymphoma, Primary Site, Summary Stage (NAACCR) p. E-57
51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
55. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
70B. Primary Site, Behavior Code ICDO3 (SEER IF39/MCR- p. E-65
72A. Primary Site, Morphology-Imposs ICDO3 (SEER IF38) p. E-67
73B. Primary Site, Morphology-Type ICDO3 (SEER IF25) p. E-70
74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
141B. RX Summ--Scope Reg LN Sur,Prim Site, ICDO3(COC)MCR p. E-89
157. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-93
158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR) p. E-94
164B. Surgery, RX Date--Surgery, ICDO3 (COC) MCR-CIMS p. E-102
183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109

field: **Histology (92-00) ICD-O-2** (called ICD-O-2 Histologic Type Code in MCR Manual)
edits: 41A. Histologic Type (COC) p. E-53
56A. Morphology--Type&Behavior (SEER MORPH) p. E-59
10A. Age, Primary Site, Morphology (NAACCR IF15) p. E-37
12A. Behavior Code, Histologic Type (NAACCR/MCR-CIMS) p. E-40
33A. Diagnostic Confirmation, Histologic Typ(SEER IF48) p. E-48
34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR) p. E-49
36A. EOD--Tumo r Size, Primary Site (NAACCR) p. E-50
38. Hemato, Summ Stage, Class of Case (NAACCR) p. E-51
39. Hemato, Summ Stage, Type of Report Srce (NAACCR) p. E-52
40A. Hematopoietic, TNM (NAACCR) p. E-52
42A. Histology ICDO2, Date of Diagnosis (NAACCR) p. E-53
43. Histology ICDO2, Histology ICDO3 (NAACCR) p. E-53
49B. Laterality, Primary Site, Morphology (NAACCR IF42) p. E-57
51A. Lymphoma, TNM (NAACCR) p. E-57
55. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
70A. Primary Site, Behavior Code (MCR-CIMS/SEER IF39) p. E-65
72B. Primary Site, Morphology-Impossible (SEER IF38) p. E-69
73A. Primary Site, Morphology-Type Check (SEER IF25) p. E-70
74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
141A. RX Summ--Scope Reg LN Sur, Primary Site (COC) MCR p. E-89
161. Summary Stage, Histology (COC) p. E-96
164A. Surgery, RX Date--Surgery (COC) MCR-CIMS p. E-101
183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109

field: **ICD-O-3 Conversion Flag**
edits: 44. ICD-O-3 Conversion Flag (NAACCR)
183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109

field: **Institution Referred From**
edits: none

field: **Institution Referred To**
edits: none

field: **Laterality**
edits: 47. Laterality (SEER LATERAL) p. E-54
48. Laterality, Primary Site (NAACCR IF24) p. E-55
49A. Laterality, Primary Site, Morph ICDO3 (NAACCR IF42) p. E-56
49B. Laterality, Primary Site, Morphology (NAACCR IF42) p. E-57
89. RML Lung, Laterality (NAACCR) p. E-76
181. Unknown Site, Laterality (NAACCR) p. E-108

field: State/Requestor Items (**Managing Physician Name**)
edits: none

field: **Marital Status at DX** (called Marital Status at Diagnosis in MCR Manual)
edits: 52. Marital Status at DX (SEER MARITAL) p. E-58
53. Marital Status at DX, Age at Diagnosis (SEER IF14) p. E-58

field: **Medical Record Number**
edits: none

field: **Name--Alias** (called Patient Alias Name in MCR Manual)
edit: 57. Name--Alias (COC) p. E-61

field: **Race 1**

edit: 75. Race 1 (SEER RACE) p. E-72
76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72

field: **Race 2**

edit: 77. Race 2 (NAACCR) p. E-73
76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
78. Race 2, Date of DX (NAACCR) p. E-73

field: **Race 3**

edit: 79. Race 3 (NAACCR) p. E-73
76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
80. Race 3, Date of DX (NAACCR) p. E-73

field: **Race 4**

edit: 81. Race 4 (NAACCR) p. E-74
76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
82. Race 4, Date of DX (NAACCR) p. E-74

field: **Race 5**

edit: 83. Race 5 (NAACCR) p. E-74
76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
84. Race 5, Date of DX (NAACCR) p. E-74

field: **Reason For No Surgery**

edits: 85. Reason for No Surgery (SEER NCDSURG) p. E-75
163. Surgery, Reason No Surg (COC) p. E-101

field: **Regional Nodes Examined**

edits: 87. Regional Nodes Examined (COC) p. E-76
34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR) p. E-49
34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR p. E-49
86. Regional Nodes Ex, Reg Nodes Pos (COC) p. E-75

field: **Regional Nodes Positive**
edits: 88. Regional Nodes Positive (COC) p. E-76
34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR) p. E-49
34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR p. E-49
86. Regional Nodes Ex, Reg Nodes Pos (COC) p. E-75
156A. Summary Stage 2000, Regional Nodes Pos (NAACCR) p. E-93
156B. Summary Stage, Regional Nodes Pos (NAACCR) p. E-97

field: **Reporting Hospital** (called Facility Code in MCR Manual)
edits: none (but must be the same for each case record in a data submission)

field: **RX Date--BRM** (called Immunotherapy -- Date Started in MCR Manual)
edits: 90. RX Date--BRM (NAACCR) p. E-76
26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
122. RX Summ--BRM, RX Date--BRM (COC) p. E-84

field: **RX Date--Chemo** (called Chemotherapy -- Date Started in MCR Manual)
edits: 91. RX Date--Chemo (NAACCR) p. E-77
26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
125. RX Summ--Chemo, RX Date--Chemo (COC) p. E-85

field: **RX Date--DX/Stg/Pall Proc** (called Diagnostic/Staging/Palliative Procedures--Date Started in MCR Manual)
edits: 92. RX Date--DX/Stg/Pall Proc (NAACCR) p. E-77
128. RX Summ--DX/Stg/Pall, RX Date--DX/Stg/Pall Proc (NAACCR p. E-86

field: **RX Date--Hormone** (called Hormone Therapy -- Date Started in MCR Manual)
edits: 93. RX Date--Hormone (NAACCR) p. E-77
26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
130. RX Summ--Hormone, RX Date--Hormone (COC) p. E-86

field: **RX Date--Other** (called Other Cancer-Directed Therapy--Date Started in MCR Manual)
edits: 94. RX Date--Other (NAACCR) p. E-77
26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
133. RX Summ--Other, RX Date--Other (COC) p. E-87

field: **RX Date--Radiation** (called Radiation Therapy -- Date Started in MCR Manual)
edits: 95. RX Date--Radiation (NAACCR) p. E-77
26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
136. RX Summ--Radiation, RX Date--Radiation (COC) p. E-88

field: **RX Date--Surgery** (called Cancer-Directed Surgery -- Date Started in MCR Manual)
edits: 96. RX Date--Surgery (NAACCR) p. E-77
26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
97. RX Date--Surgery, RX Text--Surgery (NAA/MCR-CIMS) p. E-78
164A. Surgery, RX Date--Surgery (COC) MCR-CIMS p. E-101
164B. Surgery, RX Date--Surgery, ICDO3 (COC) MCR-CIMS p. E-102

field: **RX Hosp--BRM** (called Immunotherapy -- At This Facility in MCR Manual)
edits: 97. RX Hosp--BRM (NAACCR) p. E-78
98. RX Hosp--BRM, RX Summ--BRM (COC) p. E-78

field: **RX Hosp--Chemo** (called Chemotherapy -- At This Facility in MCR Manual)
edits: 100. RX Hosp--Chemo (NAACCR) p. E-78
101. RX Hosp--Chemo, RX Summ--Chemo (COC) p. E-79

field: **RX Summ--DX/Stg/Pall Proc** (called Diagnostic/Staging/Palliative Procedures--Summary in MCR Manual)
edits: 127. RX Summ--DX/Stg/Pall Proc (COC) p. E-85
103. RX Hosp--DX/Stg/Pall, RX Summ--DX/Stg/Pall (NAACCR) p. E-79
128. RX Summ--DX/Stg/Pall, RX Date--DX/Stg/Pall Proc (NAACCR p. E-86

field: **RX Summ--Hormone** (called Hormone Therapy -- Summary in MCR Manual)
edits: 129. RX Summ--Hormone (COC) p. E-86
105. RX Hosp--Hormone, RX Summ--Hormone (COC) p. E-80
130. RX Summ--Hormone, RX Date--Hormone (COC) p. E-86
131. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS) p. E-86

field: **RX Summ--Other** (called Other Cancer-Directed Therapy -- Summary in MCR Manual)
edits: 132. RX Summ--Other (COC) p. E-87
107. RX Hosp--Other, RX Summ--Other (COC) p. E-80
133. RX Summ--Other, RX Date--Other (COC) p. E-87
134. RX Summ--Other, RX Text--Other (NAA/MCR-CIMS) p. E-87

field: **RX Summ--Radiation** (called Radiation Therapy -- Summary in MCR Manual)
edits: 135. RX Summ--Radiation (COC) p. E-87
109. RX Hosp--Radiation, RX Summ--Radiation (COC) p. E-81
136. RX Summ--Radiation, RX Date--Radiation (COC) p. E-88
162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100

field: **RX Summ--Reconstruct 1st** (called Reconstruction -- First Course in MCR Manual)
edits: 137. RX Summ--Reconstruct 1st (NAACCR) p. E-88
138. RX Summ--Reconstruct 1st, Primary Site (COC) p. E-88

field: **RX Summ--Reg LN Examined** (called Number of Regional Lymph Nodes Removed--Summary in MCR Manual)
edits: 139. RX Summ--Reg LN Examined (COC) p. E-88
142. RX Summ--Scope Reg LN Sur,RX Summ--Reg LN Ex (NPCR p. E-89

field: **RX Summ--Scope Reg LN Sur** (called Scope of Regional Lymph Node Surgery--Summary in MCR Manual)
edits: 140. RX Summ--Scope Reg LN Sur (COC) p. E-88
111. RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC) p. E-81
141A. RX Summ--Scope Reg LN Sur, Primary Site (COC) MCR p. E-89
141B. RX Summ--Scope Reg LN Sur,Prim Site, ICDO3(COC)MCR p. E-89
142. RX Summ--Scope Reg LN Sur,RX Summ--Reg LN Ex (NPCR p. E-89
162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
163. Surgery, Reason No Surg (COC) p. E-101
164A. Surgery, RX Date--Surgery (COC) MCR-CIMS p. E-101
164B. Surgery, RX Date--Surgery, ICDO3 (COC) MCR-CIMS p. E-102

field: **RX Summ--Surg Oth Reg/Dis** (called Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes--Summary in MCR Manual)
edits: 143. RX Summ--Surg Oth Reg/Dis (COC) p. E-89
115. RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC) p. E-82
144. RX Summ--Surg Oth Reg/Dis, Primary Site (COC) p. E-90
162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
163. Surgery, Reason No Surg (COC) p. E-101
164A. Surgery, RX Date--Surgery (COC) MCR-CIMS p. E-101
164B. Surgery, RX Date--Surgery, ICDO3 (COC) MCR-CIMS p. E-102

field: **RX Summ--Surg Prim Site** (called Surgery of Primary Site--Summary in MCR Manual)
edits: 145. RX Summ--Surg Prim Site (COC) p. E-90
118. RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC) p. E-83
146. RX Summ--Surg Prim Site, Diag Conf (SEER IF76) p. E-90
147. RX Summ--Surg Prim Site, Primary Site (COC) p. E-90
162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
163. Surgery, Reason No Surg (COC) p. E-101
164A. Surgery, RX Date--Surgery (COC) MCR-CIMS p. E-101
164B. Surgery, RX Date--Surgery, ICDO3 (COC) MCR-CIMS p. E-102

field: **RX Summ--Surg/Rad Seq** (called Radiation / Surgery Sequence in MCR Manual)
edits: 148. RX Summ--Surg/Rad Seq (SEER RADSEQ) p. E-90
162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100

field: **RX Text--BRM** (called Immunotherapy -- Narrative in MCR Manual)
edit: 123. RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS) p. E-84

field: **RX Text--Chemo** (called Chemotherapy -- Narrative in MCR Manual)
edit: 126. RX Summ--Chemo, RX Text--Chemo (NAACR/MCR-CIMS) p. E-85

field: **RX Text--Hormone** (called Hormone Therapy -- Narrative in MCR Manual)
edit: 131. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS) p. E-86

field: **RX Text--Other** (called Other Cancer-Directed Therapy -- Narrative in MCR Manual)
edit: 134. RX Summ--Other, RX Text--Other (NAA/MCR-CIMS) p. E-87

field: **RX Text--Radiation (Beam)** (called Radiation Therapy -- Narrative in MCR Manual)
edits: none

field: **RX Text--Surgery** (called Surgery -- Narrative in MCR Manual)
edit: 97. RX Date--Surgery, RX Text--Surgery (NAA/MCR-CIMS) p. E-78

field: **SEER Summary Stage 1977**
edits: 154A. Summary Stage (NAACCR) p. E-92
14A. Behavior, Summary Stage (NAACCR) p. E-41
38. Hemato, Summ Stage, Class of Case (NAACCR) p. E-51
39. Hemato, Summ Stage, Type of Report Srce (NAACCR) p. E-52
50. Lymphoma, Primary Site, Summary Stage (NAACCR) p. E-57
155B. Summary Stage, Date of Diagnosis (NAACCR) p. E-96
161. Summary Stage, Histology (COC) p. E-96
156B. Summary Stage, Regional Nodes Pos (NAACCR) p. E-97
159B. Summary Stage, TNM M (NAACCR) p. E-98
160B. Summary Stage, TNM N (NAACCR) p. E-99
182. Unknown Site, Summary Stage (NAACCR) p. 109

field: **SEER Summary Stage 2000**
edits: 154B. Summary Stage 2000 (NAACCR) p. E-92
14B. Behavior, Summary Stage 2000 (NAACCR) p. E-42
155A. Summary Stage 2000, Date of Diagnosis (NAACCR) p. E-92
156A. Summary Stage 2000, Regional Nodes Pos (NAACCR) p. E-93
157. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-93
158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR) p. E-94
159A. Summary Stage 2000, TNM M (NAACCR) p. E-95
160A. Summary Stage 2000, TNM N (NAACCR) p. E-96

field: **Type of Reporting Source**
edits: 180. Type of Reporting Source (SEER RPRTSRC) p. E-108
14B. Behavior, Summary Stage 2000 (NAACCR) p. E-42
19. Class of Case, Type of Reporting Source (NAACCR) p. E-43
34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR) p. E-49
34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR p. E-49
36A. EOD--Tumor Size, Primary Site (NAACCR) p. E-50
36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR) p. E-51
39. Hemato, Summ Stage, Type of Report Srce (NAACCR) p. E-52
40A. Hematopoietic, TNM (NAACCR) p. E-52
40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR) p. E-94
177. Type of Report Srce(DC/AO), Date of Dx (SEER IF02) p. E-107
178. Type of Report Srce(DC/AO), Diag Conf (SEER IF05) p. E-108
179. Type of Report Srce(DC/AO), Vit Stat (COC) p. E-108

field: **Vendor Name** (called Vendor Name / Version Number in MCR Manual)
edits: none

field: **Vital Status**
edits: 184. Vital Status (COC) p. E-110
20. Class, Date Diag, Date Last Cont, Vit Stat (COC) p. E-44
67. Place of Death, Vital Status (NAACCR) p. E-64
179. Type of Report Srce(DC/AO), Vit Stat (COC) p. E-108

field: **Year First Seen This CA** (called Year Fist Seen for This Primary in MCR Manual)
edits: 185. Year First Seen This CA (COC) p. E-110
114. RX Hosp--Scope Reg LN Sur,RX Hosp--Reg LN Ex (COC p. E-82
141A. RX Summ--Scope Reg LN Sur, Primary Site (COC) MCR p. E-89
141B. RX Summ--Scope Reg LN Sur,Prim Site, ICDO3(COC)MCR p. E-89
186. Year First Seen This CA, Date of DX (NAACCR) p. E-110

70A. **Primary Site, Behavior Code (MCR-CIMS/SEER IF39)**

fields involved: Behavior (92-00) ICD-O-2
Histology (92-00) ICD-O-2
Primary Site

The edit is skipped for a case record if the ICD-O-2 histologic type code is empty. The edit is skipped if either ICD-O-2 Behavior or Primary Site has failed its validity check.

This edit does two different things. It has a SEER check, and a MCR check.

The SEER part of this edit questions a combination of *in situ* behavior and a vague primary site. SEER provides the following explanation and advice:

> Since the designation of *in situ* is very specific and almost always requires microscopic confirmation, it is assumed that specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being *in situ* is reliable. Therefore this edit does not allow an *in situ* behavior code to be used with specified organ systems and ill-defined site codes.
>
> ...Check the information available about primary site and histologic type carefully. If a specific *in situ* diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system may sometimes be assumed based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is probably preferable to code a behavior code of **3**.

The edit questions the following primary sites when reported with an ICD-O-2 Behavior of **2**:

C269	gastrointestinal tract, NOS	**C689**	urinary system, NOS
C399	ill-defined sites within respiratory system	**C729**	nervous system, NOS
C559	uterus, NOS	**C759**	endocrine gland, NOS
C579	female genital tract, NOS	**C76_**	ill-defined sites
C639	male genital organs, NOS	**C809**	unknown primary site

Note that the edit does not look at staging fields. It solely uses the ICD-O-2 Behavior code to determine if the case is being called *in situ* or non-invasive.

The MCR part of this edit questions an uncertain or benign ICD-O-2 behavior with any non-meninges/brain/CNS primary site. Because the MCR collects cases with these behaviors *only* for meninges, brain and other central nervous system primaries, we need an edit to check that these behaviors are not submitted for other sites. The following code combinations are questioned by this part of the edit:

ICD-O-2 Behavior = **0** or **1** and Primary Site <> **C700** - **C729** (meninges, brain, other parts of CNS)

This edit has an over-ride (for both parts) called “Site/Behavior”.

(There is no logical relationship between the SEER and MCR parts of this edit. The MCR needed an edit to limit certain behaviors to certain primary sites, and this SEER edit just happened to involve the fields necessary to do that.)

70B. **Primary Site, Behavior Code ICDO3 (SEER IF39/MCR-**

fields involved: Behavior Code ICD-O-3
Histologic Type ICD-O-3
Primary Site

This is the ICD-O-3 version of the preceding edit.

It skips if the ICD-O-3 Histology is empty. It skips if the validity check on ICD-O-3 Behavior or Primary Site has failed.

It works just like the preceding SEER/MCR edit, using the ICD-O-3 Behavior instead of the ICD-O-2.

The same over-ride (“Site/Behavior”) applies to this edit.

141A. **RX Summ--Scope Reg LN Sur, Primary Site (COC) MCR**

fields involved: Histology (92-00) ICD-O-2
Primary Site
RX Summ--Scope Reg LN Sur
Year First Seen This CA

This edit checks that the summary regional node surgery code is valid for the diagnosis coded. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS. The edit consults a look-up table of valid codes.

If Year First Seen for This Cancer > **1999**, then the regional node surgery code can only be **9** for leukemias (**9800-9941**), nodal lymphomas (**C77_** with **9590-9698**, **9702-9717**), brain primaries (**C700, C71_**), and unknown primaries (**C809**).*

The edit skips for a case record if the ICD-O-2 histology code is empty.

* If your data system does not allow **9** to be entered for Scope of Regional Lymph Node Surgery when no surgery was performed, code **0** will not be called an error.

141B. **RX Summ--Scope Reg LN Sur,Prim Site, ICDO3(COC)MCR**

fields involved: Histologic Type ICD-O-3
Primary Site
RX Summ--Scope Reg LN Sur
Year First Seen This CA

This is the ICD-O-3 version of the preceding edit. It behaves just like the preceding edit, but the leukemias are defined by code range **9800 - 9989** and the nodal lymphomas are defined by **9590 - 9699**, **9702 - 9729**. If your data system will not allow you to enter **9** for Scope of Regional Lymph Node Surgery for leukemias, nodal lymphomas, brain primaries and unknown primaries, then a code **0** will not be called an error.

The edit skips if the ICD-O-3 histology code is empty.

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142. **RX Summ--Scope Reg LN Sur,RX Summ--Reg LN Ex (NPCR**

fields involved: Date of Diagnosis (year only)
RX Summ--Reg LN Examined
RX Summ--Scope Reg LN Sur

This edit looks for compatibility between the summary fields for scope of node surgery and number of nodes removed.

This edit is skipped whenever the case record's year of diagnosis is less than **1998**.

If the summary "scope" code indicates that no regional node surgery was done (**0**), then the summary number of nodes removed must indicate that none were removed surgically (**00**) or that some were aspirated only (**95**).

If the summary "scope" code indicates that regional node surgery was done (**1 - 8**), then the summary number of nodes must be a specific number surgically removed (**01 - 90**) or an unknown number surgically removed (**96 - 98**).

If the summary "scope" code indicates that it's unknown if node surgery was done (**9**), then the unknown code must also be coded for the summary number of nodes removed (**99**).

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143. **RX Summ--Surg Oth Reg/Dis (COC)**

field involved: RX Summ--Surg Oth Reg/Dis (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit).

The field cannot be empty.

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163. **Surgery, Reason No Surg (COC)**

fields involved: Reason for No Surgery
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site

This edit checks for agreement between the "Reason for No" field and the summary (cancer-directed) surgery fields.

The edit is skipped for a case record if any of these fields is empty.

If the summary codes indicate that surgery was not done, then the "Reason for No" code cannot indicate that it was done. That is, the edit wants this code combination:

[RX Summ--Scope Reg LN Sur = **0**
and RX Summ--Surg Oth Reg/Dis = **0**
and RX Summ--Surg Prim Site = **00**] and Reason for No Surgery <> **0**

If a summary code(s) indicates that some surgery was done, then the "Reason for No" code must also indicate that it was done. That is, the edit wants this code combination:

[RX Summ--Scope Reg LN Sur = **1**-**8**
or RX Summ--Surg Oth Reg/Dis = **1**-**8**
or RX Summ--Surg Prim Site = **10**-**90**] and Reason for No Surgery = **0**

Note that unknown codes are missing from these checks. If it's unknown whether any surgery was done, the "Reason for No" field is not checked and can contain any code. That is, the edit will pass this combination of codes:

[RX Summ--Scope Reg LN Sur = **9**
and RX Summ--Surg Oth Reg/Dis = **9**
and RX Summ--Surg Prim Site = **99**] and Reason for No Surgery = **0**-**2**, **6**-**9**

164A. **Surgery, RX Date--Surgery (COC)** MCR-CIMS

fields involved: Histology (92-00) ICD-O-2
Primary Site
RX Date--Surgery (year only)
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site

This edit checks that the year (cancer-directed) surgery started is not coded in conflict with the surgery summary codes. Keep in mind that the Scope of Regional Lymph Node Surgery is now coded **9** for leukemias (**9800 - 9941**), nodal lymphomas (**C770-C779**, **9590-9698**, **9702-9717**), brain primaries (**C700**, **C710 - C719**) and unknown primary site (**C809**); but that these diagnoses were not always limited to code **9** in the past.*

If the summary codes indicate that no surgery was done, then the year must be zero-filled to indicate that none was done. That is, the edit wants this combination of codes:

[RX Summ--Scope Reg LN Sur = **0** (or **9*** for leukemias, nodal lymphomas, brain primaries, unknown primary)
and RX Summ--Surg Oth Reg/Dis = **0**
and RX Summ--Surg Prim Site = **00**] and RX Date--Surgery = **00000000**

If the summary codes indicate surgery was done, then the year can't be zero-filled. The edits wants this code combination:

[RX Summ--Scope Reg LN Sur = **1-9** (or **1-8** for leukemias, nodal lymphomas, brain primary, unknown primary)
and RX Summ--Surg Oth Reg/Dis > **0**
and RX Summ--Surg Prim Site ≥ **10**] and RX Date--Surgery <> **00000000**

Note that if the Primary Site Surgery or Surgery of Other… summary codes indicate that it's unknown whether or not surgery was recommended/done (**99**, **9**), then the date does not have to be **9**-filled -- it can be any date except **00000000**.

The edit skips any case record in which any of the involved fields is empty.

* If your data system does not allow **9** to be entered for Scope of Regional Lymph Node Surgery when no surgery was performed, code **0** will not be called an error.

164B. **Surgery, RX Date—Surgery, ICDO3 (COC)** MCR-CIMS

fields involved: Histologic Type ICD-O-3
Primary Site
RX Date--Surgery
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site

This is an ICD-O-3 version of the preceding edit. It works exactly like the preceding edit, but leukemias and nodal lymphomas are defined by the ICD-O-3 histology code ranges **9800 - 9989** and **9590 - 9699**, **9702 - 9729**.

The February 2002 revision to the preceding edit also applies to this edit. That is, if your data system will not allow you to code Scope of Regional Lymph Node Surgery with **9** for leukemias, nodal lymphomas, brain primaries and unknown primaries, then a code **0** will not be called an error.

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165. **TNM Clin M (COC)**

field involved: TNM Clin M (2 characters long)

This is a simple validity check.

Valid codes are:

X_
0_
1_
1A
1B
1C
88

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your M field comes to us containing just an **X** without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the pathologic M edit are identical to these.

The field can be empty. (The validity check skips a case record if the clinical M is empty.)
